

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046078</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Countryview Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>R.R. Box 195</u> <u>Louisville</u> <u>62858</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Clay</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(618) 686-4542</u> Fax # <u>(618) 686-2179</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>																									
IDPA ID Number: <u>3713463060001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>02/01/96</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace# 0046078 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,856</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,856</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,668</u>			<u>5,668</u>	13
14	TOTALS	<u>5,668</u>			<u>5,668</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.79%

D. How many bed-hold days during this year were paid by Public Aid?

2

(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/01/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 02/01/96NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	24,163	2,310		26,473		26,473	1,234	27,707			1
2	Food Purchase		14,830		14,830		14,830		14,830			2
3	Housekeeping		2,846		2,846		2,846	5	2,851			3
4	Laundry		605		605		605		605			4
5	Heat and Other Utilities			11,351	11,351		11,351	112	11,463			5
6	Maintenance	4,491	8,455	562	13,508		13,508	771	14,279			6
7	Other (specify):* mgmt alloc of benefits							221	221			7
8	TOTAL General Services	28,654	29,046	11,913	69,613		69,613	2,343	71,956			8
	B. Health Care and Programs											
9	Medical Director			7,512	7,512		7,512		7,512			9
10	Nursing and Medical Records	111,329	2,866	228	114,423		114,423	2,711	117,134			10
10a	Therapy							1	1			10a
11	Activities		154		154		154	1	155			11
12	Social Services	2,332	27		2,359		2,359		2,359			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* mgmt alloc of benefits							262	262			15
16	TOTAL Health Care and Programs	113,661	3,047	7,740	124,448		124,448	2,975	127,423			16
	C. General Administration											
17	Administrative	29,583		55,446	85,029		85,029	(40,301)	44,728			17
18	Directors Fees											18
19	Professional Services			5,584	5,584		5,584	2,735	8,319			19
20	Dues, Fees, Subscriptions & Promotions			769	769		769	122	891			20
21	Clerical & General Office Expenses		1,364	10,934	12,298		12,298	9,358	21,656			21
22	Employee Benefits & Payroll Taxes			38,987	38,987		38,987		38,987			22
23	Inservice Training & Education			18	18		18	156	174			23
24	Travel and Seminar			126	126		126	331	457			24
25	Other Admin. Staff Transportation			3,872	3,872		3,872	637	4,509			25
26	Insurance-Prop.Liab.Malpractice			19,767	19,767		19,767	223	19,990			26
27	Other (specify):* mgmt alloc of benefits							2,569	2,569			27
28	TOTAL General Administration	29,583	1,364	135,503	166,450		166,450	(24,170)	142,280			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	171,898	33,457	155,156	360,511		360,511	(18,852)	341,659			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Countryview Terrace

#0046078

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			18,405	18,405		18,405	7,142	25,547			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,288	33,288		33,288	1,261	34,549			32
33	Real Estate Taxes			4,691	4,691		4,691	82	4,773			33
34	Rent-Facility & Grounds							639	639			34
35	Rent-Equipment & Vehicles							22	22			35
36	Other (specify):*											36
37	TOTAL Ownership			56,384	56,384		56,384	9,146	65,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,804	30,804		30,804		30,804			42
43	Other (specify):* Nonallowable Costs			1,197	1,197		1,197	(1,197)				43
44	TOTAL Special Cost Centers			32,001	32,001		32,001	(1,197)	30,804			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	171,898	33,457	243,541	448,896		448,896	(10,903)	437,993			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(123)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	6,039	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(125)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(810)	43		24
25 Fund Raising, Advertising and Promotional	(139)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 4,842		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(15,745)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (15,745)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (10,903)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider #: 0046078
01/01/04 to 12/31/04

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
-------------------------------	---------------	------------------

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview TerraceID# 0046078Report Period Beginning: 01/01/04Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/04

[illegible]

Summary B

12/31/04

[illegible]

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,234	\$ 1,234 1
2	V	2 Food		Petersen Health Care, Inc.	100.00%		
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	5	5 3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	112	112 4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	771	771 5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	221	221 6
7	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,711	2,711 7
8	V	10A Therapy		Petersen Health Care, Inc.	100.00%	1	1 8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	1	1 9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	262	262 10
11	V	17 Administrative	55,446	Petersen Health Care, Inc.	100.00%	15,145	(40,301) 11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,735	2,735 12
13	V	20 Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	122	122 13
14	Total		\$ 55,446			\$ 23,320	\$ * (32,126) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 9,358	\$ 9,358 15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	156	156 16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	331	331 17
18	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	637	637 18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	223	223 19
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,569	2,569 20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,103	1,103 21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,261	1,261 22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	82	82 23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	639	639 24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	22	22 25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$			\$ 16,381	\$ * 16,381 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
00041715
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,077,844	1	2.50	Salary	\$ 15,145	L17, C8	1
2											2
3											3
4	See attached Schedule 7A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,145		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
00041715
12/31/2004

Schedule 7A

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace# 0046078 Report Period Beginning: 01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care CompaniesStreet Address 7218 North Villa LakeCity / State / Zip Code Peoria, IL 61614Phone Number (309) 691-8113Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	\$ 89,079	\$ 89,071	5,668	\$ 1,234	1
2	2	Food	Patient Days	409,056	18	33		5,668	0	2
3	3	Housekeeping	Patient Days	409,056	18	372		5,668	5	3
4	5	Utilities	Patient Days	409,056	18	8,082		5,668	112	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	5,668	771	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		5,668	221	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	5,668	2,711	7
8	10A	Therapy	Patient Days	409,056	18	75		5,668	1	8
9	11	Activities	Patient Days	409,056	18	86		5,668	1	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		5,668	262	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	5,668	15,145	11
12	19	Professional Services	Patient Days	409,056	18	197,418		5,668	2,735	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		5,668	122	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	5,668	9,358	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		5,668	156	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		5,668	331	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		5,668	637	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		5,668	223	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		5,668	2,569	19
20	30	Depreciation	Patient Days	409,056	18	79,620		5,668	1,103	20
21	32	Interest	Patient Days	409,056	18	90,987		5,668	1,261	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		5,668	82	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		5,668	639	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		5,668	22	24
25	TOTALS					\$ 2,865,264	\$ 1,919,411		\$ 39,701	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace# 0046078

Report Period Beginning:

01/01/04

Ending:

12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	\$649 plus int.	08/31/02	\$ 479,263	\$ 460,572	08/31/07	Varies	\$ 31,175	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Nick Adkins Brokerage		X	Commission Note	\$284.00	09/10/96	225,000	0	08/10/06	0.0900	671	6
7	LaSalle Bank		X	Line of Credit	Interest Only	08/31/02	54,387	0	08/31/2005	Varies	1,442	7
8												8
9	TOTAL Facility Related				\$284.00		\$ 758,650	\$ 460,572			\$ 33,288	9
	B. Non-Facility Related*											
10							Allocated from Home Office				1,261	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 1,261	14
15	TOTALS (line 9+line14)						\$ 758,650	\$ 460,572			\$ 34,549	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Countryview Terrace**# **0046078** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	4,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2003	\$	4,596	2
3. Under or (over) accrual (line 2 minus line 1).			\$	96	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4,595	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Allocation from home office	\$	82	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	4,773	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	4,361	8
	2000	4,508	9
	2001	4,508	10
	2002	4,510	11
	2003	4,596	12

2003 Tax Bill:	4596		
	-1		
Est. Accrual:	4595		

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Terrace COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046078

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>02-15-100-030</u>	<u>SEC 15-5-6-PT SE NW S&W of</u>	<u>\$ 4,596.00</u>	<u>\$ 4,596.00</u>
2. _____	<u>OLD US 45 - 7.63 AC</u>	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
TOTALS		<u>\$ 4,596.00</u>	<u>\$ 4,596.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

4,416

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

One

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	402,930	1996	\$ 10,000	1
2					2
3	TOTALS	402,930		\$ 10,000	3

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1996	1976	\$ 579,889	\$ 14,869	35	\$ 16,568	\$ 1,699	\$ 148,986
5									
6									
7									
8									
Improvement Type**									
9	Land Survey	1996		1,700		20	85	85	737
10	Curtains	1996		307		20	15	15	128
11	Pump Repairs	1996		1,163		20	58	58	508
12	Repiping Water Heater	1996		1,681		20	84	84	721
13	Fence	1997		2,469	149	20	123	(26)	892
14	Plumbing	1997		1,234		20	62	62	475
15	Handicapped Showers & Ramp	1998		1,962	50	20	98	48	637
16	Landscaping	2000		4,289	297	20	214	(83)	963
17	Drainage and Sidewalk	2001		2,557	66	20	128	62	449
18	Roof	2001		8,701	223	20	435	212	1,523
19	Water Supply	2002		2,413	62	20	121	59	302
20	Roof	2004		900	16	20	23	7	23
21	Bathroom Sinks and Showers	2004		12,800	14	20	320	306	320
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 622,065	\$ 15,746		\$ 18,334	\$ 2,588	\$ 156,664	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 38,766	\$ 1,055	\$ 3,877	\$ 2,822	10	\$ 30,946	71
72	Current Year Purchases	4,725	732	236	(496)	10	236	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			1,103	1,103			74
75	TOTALS	\$ 43,491	\$ 1,787	\$ 5,216	\$ 3,429		\$ 31,182	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident use	1995 Dodge Maxivan	1999	\$ 9,986	\$ 872	\$ 1,997	\$ 1,125	5	\$ 8,237	76
77										77
78										78
79										79
80	TOTALS			\$ 9,986	\$ 872	\$ 1,997	\$ 1,125		\$ 8,237	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 685,542	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,405	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,547	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,142	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 196,083	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5		Allocated from Home Office			639			5
6								6
7	TOTAL				\$ 639			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

N/A

N/A

N/A

9. Option to Buy:

☐

YES

☐

NO

Terms:

N/A

*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES

☐ NO

16. Rental Amount for movable equipment: \$ 22

Description:

Allocated from Home Office - \$22

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2005

\$

13. /2006

\$

14. /2007

\$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider #: 0046078
01/01/04 to 12/31/04

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
----------------	---------------------------	-------------------------------------	-------------	-----------------

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 74,139	\$ 74,139	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	128,242	128,242	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	116,121	116,121	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 318,502	\$ 318,502	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,169	10,000	13
14	Buildings, at Historical Cost	613,818	622,065	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	53,477	53,477	16
17	Accumulated Depreciation (book methods)	(183,321)	(196,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 498,143	\$ 489,459	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 816,645	\$ 807,961	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 35,750	\$ 35,750	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,368	8,368	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,595	4,595	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See attached schedule 17A</u>	10,447	10,447	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 59,160	\$ 59,160	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	460,572	460,572	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 460,572	\$ 460,572	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 519,732	\$ 519,732	46
47	TOTAL EQUITY (page 18, line 24)	\$ 296,913	\$ 288,229	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 816,645	\$ 807,961	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

FACILITY NAME Countryview Terrace
PROVIDER # 00041715
12/31/2004

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.
C. Current Liabilities

		After
Other Current Liabilities (specify):	Operating	Consolidation
Due to Due from	166	166
Due to Patients	-	-
Assessments	-	-
Accrued Vacation	1,742	1,742
Accrued Sales Tax	23	23
Accrued Insurance - General	788	788
Accrued Insurance - W/C	(805)	(805)
Accrued Expenses - Other	8,533	8,533
Total Line 36 - Other Current Liabilities(specify):	10,447	10,447

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 151,071	1
2	Restatements (describe):		2
3	Prior Period Adjustment	86,671	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 237,742	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	59,171	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 59,171	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 296,913	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 507,557	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 507,557	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation</u>	510	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 510	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 508,067	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	69,613	31
32	Health Care	124,448	32
33	General Administration	166,450	33
B. Capital Expense			
34	Ownership	56,384	34
C. Ancillary Expense			
35	Special Cost Centers	1,197	35
36	Provider Participation Fee	30,804	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 448,896	40
41	Income before Income Taxes (line 30 minus line 40)**	59,171	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 59,171	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Countryview Terrace

0046078

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	13,952	14,412	111,329	7.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	218	240	2,332	9.72	11
12	Dietician					12
13	Food Service Supervisor	2,109	2,318	24,163	10.42	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	579	579	4,491	7.76	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,907	1,907	29,583	15.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,765	19,456	\$ 171,898 *	\$ 8.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	7,512	9(3)	36
37	Medical Records Consultant	3 visits	36	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 visits	192	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 7,740		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Miranda Wattles	Aministrator	0	\$ 29,583	Workers' Compensation Insurance		\$ 11,627	IDPH License Fee		\$ 500		
				Unemployment Compensation Insurance		2,805	Advertising; Employee Recruitment		51		
				FICA Taxes		13,172	Health Care Worker Background Check (Indicate # of checks performed <u>13</u>)		142		
				Employee Health Insurance		9,963	License & permits		75		
				Employee Meals			Dues & Subscription		1		
				Illinois Municipal Retirement Fund (IMRF)*			Home Office Allocation		122		
				Retirement		306					
				Employee Morale		1,114					
	</										

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Countryview Terrace
Provider #: 0046078
01/01/04 to 12/31/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 5,584

Allocated from Management Company

Professional Services - Accounting 447

Professional Services - Other 2,288

Total (agree to Schedule V, line 19, column 8) 8,319

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number <u>Countryview Terrace</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. <u>N/A</u></p> <p>(3) Did the nursing home make political contributions or payments to a political organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>None</u> Line <u>N/A</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>30,804</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0046078</u> Report Period Beginning: <u>01/01/04</u> Ending: <u>12/31/04</u> Page 23</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>N/A</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>N/A</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0</u> d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>N/A</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>Ginoli & Co.</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>No</u> If no, please explain. <u>Audit in progress</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
---	---

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	24,163	2,310	0	26,473	0	26,473	1,234	27,707
2. Food Purchase	0	14,830	0	14,830	0	14,830	0	14,830
3. Housekeeping	0	2,846	0	2,846	0	2,846	5	2,851
4. Laundry	0	605	0	605	0	605	0	605
5. Heat and Other Utilities	0	0	11,351	11,351	0	11,351	112	11,463
6. Maintenance	4,491	8,455	562	13,508	0	13,508	771	14,279
7. Other (specify)*	0	0	0	0	0	0	221	221
8. Total General Services	28,654	29,046	11,913	69,613	0	69,613	2,343	71,956
9. Medical Director	0	0	7,512	7,512	0	7,512	0	7,512
10. Nursing & Medical Records	111,329	2,866	228	114,423	0	114,423	2,711	117,134
10a. Therapy	0	0	0	0	0	0	1	1
11. Activities	0	154	0	154	0	154	1	155
12. Social Services	2,332	27	0	2,359	0	2,359	0	2,359
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	262	262
16. Total Health Care & Programs	113,661	3,047	7,740	124,448	0	124,448	2,975	127,423
17. Administrative	29,583	0	55,446	85,029	0	85,029	-40,301	44,728
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,584	5,584	0	5,584	2,735	8,319
20. Fees, Subscriptions & Promotion	0	0	769	769	0	769	122	891
21. Clerical & General Office	0	1,364	10,934	12,298	0	12,298	9,358	21,656
22. Employee Benefits & Payroll	0	0	38,987	38,987	0	38,987	0	38,987
23. Inservice Training & Education	0	0	18	18	0	18	156	174
24. Travel and Seminar	0	0	126	126	0	126	331	457
25. Other Admin. Staff Trans	0	0	3,872	3,872	0	3,872	637	4,509
26. Insurance-Prop.Liab.Malpractice	0	0	19,767	19,767	0	19,767	223	19,990
27. Other (specify)*	0	0	0	0	0	0	2,569	2,569
28. Total General Adminis	29,583	1,364	135,503	166,450	0	166,450	-24,170	142,280
29. Total General Administrative	171,898	33,457	155,156	360,511	0	360,511	-18,852	341,659
30. Depreciation	0	0	18,405	18,405	0	18,405	7,142	25,547
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	33,288	33,288	0	33,288	1,261	34,549
33. Real Estate	0	0	4,691	4,691	0	4,691	82	4,773
34. Rent - Facility & Grounds	0	0	0	0	0	0	639	639
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	22	22
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	56,384	56,384	0	56,384	9,146	65,530
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	30,804	30,804	0	30,804	0	30,804
43. Other (specify):*	0	0	1,197	1,197	0	1,197	-1,197	0
44. Total Special Cost Ce	0	0	32,001	32,001	0	32,001	-1,197	30,804
45. Grand Total	171,898	33,457	243,541	448,896	0	448,896	-10,903	437,993

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	74,139	74,139
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	128,242	128,242
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	116,121	116,121
9. Other (specify):	0	0
10. Total current assets	318,502	318,502
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	14,169	10,000
14. Buildings, at Historical Cost	613,818	622,065
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	53,477	53,477
17. Accumulated Depreciation (book methods)	-183,321	-196,083
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	498,143	489,459
25. Total Assets	816,645	807,961
CURRENT LIABILITIES		
26. Accounts Payable	35,750	35,750
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	8,368	8,368
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	4,595	4,595
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	10,447	10,447
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	59,160	59,160
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	460,572	460,572
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	460,572	460,572
46.Total Liabilities	519,732	519,732
47.Total Equity	296,913	288,229
48.Total Liabilities and Equity	816,645	807,961

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	507,557
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	507,557
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	510
28. Other Revenue (specify):	0
Subtotal - Other Revenue	510
30. Total Revenue	508,067
31. General Services	69,613
32. Health Care	124,448
33. General Administration	166,450
34. Ownership	56,384
35. Special Cost Centers	1,197
35. Provider Participation Fee	30,804
37. Other	0
40. Total Expenses	448,896
41. Income Before Income Taxes	59,171
42. Income Taxes	0
43. Net Income or Loss for the Year	59,171

Page

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23